Exhibit B

City of Kalamazoo
Program Criteria: *OTHER QUALIFIED ADULT*

The City of Kalamazoo's medical and dental coverage shall extend to Other Qualified Adults who meet the eligibility requirements set forth below:

1. Evidence that the Employee and *Other Qualified Adult* share a common principal residence, having done so for at least twelve (12) consecutive months;

2. *Other Qualified Adult* is not eligible to inherit from the Employee under the laws of intestate succession in the state of Michigan;

3. Both the employee and *Other Qualified Adult* are unmarried, single persons;

4. *Other Qualified Adult* is not an employee of the City nor a renter, boarder, landlord or tenant of the City employee.

5. Neither the employee nor *Other Qualified Adult* are a dependent, as that term is defined by the Internal Revenue Service, of the other; and

6. Eligibility to continue coverage for another qualified adult ceases at the end of a month in which any of the above criteria are not met. Employees are required to immediately notify the City of Kalamazoo Human Resources Department of a change in eligibility status.

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City of Kalamazoo
AFFIDAVIT OF OTHER QUALIFIED ADULT

The undersigned understand and acknowledge:

1. If it is determined that any of the qualifying criteria listed above are not true and that benefits paid as a result should not have been paid, the undersigned are jointly and individually responsible to fully reimburse the City for the value of the benefits paid. If such reimbursement is not paid, the City may file suit against one or both individuals. If the City receives a judgment for all or part of the amount sought, the City shall also be entitled to recover costs, interest and reasonable attorney fees incurred in the effort.

2. If any of the above listed criteria cease to be true one or both persons shall, within 14 days, notify the City in writing. Failure by the employee to do so may be grounds for disciplinary action up to and including termination.

3. The extending by the City of benefits to one or both of the parties because of this certificate may have tax consequences (e.g., the benefit may be deemed "income," giving rise to income tax). Any such liabilities shall not be the responsibility of the City.

_____ _____

Employee Name **Other Qualified Adult Name**

_____ _____

Social Security Number **Social Security Number**

_____

Home Address (street, city, state, zip code)

_____ _____

Employee Signature **Other Qualified Adult Signature**

_____ _____

Date **Date**

STATE OF MICHIGAN }
}ss.
COUNTY OF KALAMAZOO }

Subscribed and sworn to before me this

_____ day of _____,

200__.

_____
, Notary Public

Kalamazoo County, Michigan

My Commission expires: _____

City of Kalamazoo
AFFIDAVIT OF TERMINATION OF OTHER QUALIFIED ADULT

I, _____, affirm that the Other

Qualified Adult described in my affidavit dated _____, terminated as of

_____.

I hereby agree to mail a copy of this Affidavit to my surviving former other qualified adult.

_____ _____

Employee Signature **Date**

STATE OF MICHIGAN }
}ss.
COUNTY OF KALAMAZOO }

Subscribed and sworn to before me this

_____ day of _____,

200__.

_____
, Notary Public

Kalamazoo County, Michigan

My Commission expires: _____

Revised: 5/16/08

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